Inpatient Services for Children

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IN RECENT YEARS, there has been constantly increasing pressure to provide mental health facilities for the care and treatment of a group of children who cannot be adequately dealt with on an outpatient basis. These children, for the most part, are in the 5- to 15-year age group. Allowing for difficulties in diagnosis, the group includes cases that may be classified under the broad headings of schizophrenia, severe psychoneurosis, and the behavior disorders. By and large, it excludes cases showing mental retardation—although there is serious doubt whether they should always be excluded—and, also, cases showing manifest organic pathology of the central nervous system.

This pressure has shown itself in many ways. More and more children have been referred to the few facilities which have residential treatment programs; normal foster care institutions indicate an increasing awareness of specialized treatment needs in the children for whom they care; and those State hospitals admitting children find themselves with a steadily growing patient population in this age group. It is my impression that this trend is related more to increased diagnostic skills and broader treatment perspectives than it is to a change in the incidence of severely disturbed children in this age group. It also reflects an increasing professional conviction that the small institution giving intensive treatment has something special to offer to these children.

If we take an overview of the field of inpatient mental health services for children, we are confronted with a confusing array. The facilities go by many names: psychiatric hospitals, training schools, and residential treatment homes or treatment centers. Their treatment programs may include all or none of the organic therapies, remedial education, individual psychotherapy, group therapy, or casework with families; their goals range from diagnosis on a short-term basis through long-range custody and on to active treatment programs. The institutions may be integrated with other community treatment facilities or may be in extreme isolation. The staff may be professional or not, under medical direction or not. The institutions may be large or small, ranging in size from only 20 beds to more than 200. And, finally, the children display the most disconcerting heterogeneity. At the very least they are both boys and girls, but in addition they range in age from 2 to 15, in symptomatology from severe aggressiveness to extreme withdrawal, and they fall into many diagnostic categories.

By and large, there has been the parallel but isolated growth of three classes of institu-

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tions, each with its own philosophy, each believing that it is dealing with a discrete and separable group of children. These three classes of institutions are, broadly, psychiatric hospitals, dealing medically with mentally ill children; foster care institutions designed to care for the normal dependent and neglected child; and training schools and their counterparts, essentially caring for the aggressive, antisocial, or delinquent child. Of principal importance at the moment is the parochialism that has resulted from this development—a parochialism that affects conceptions both of the child and of the treatment process. Thus, the child is thought of as mentally ill and therefore the province of the hospital, or as emotionally disturbed and belonging to the guidance clinic or social agency, or he is delinquent and belongs to the courts and training schools. Correspondingly, the psychiatrist often is woefully ignorant of the importance of such things as the social structure of his institution or casework with the family of a disturbed child; the social agency often is unable to integrate modern psychiatric knowledge into its program. While things have been changing for the better, it is only fair to recognize that we have inherited this splitup view of the child and of treatment, and that it is a handicap. Moreover, power and prestige considerations make it difficult to give up a position once it has been taken.

Inpatient Facilities

Of specific relevance to State planning are the following questions, which are, however, of a partial and limited character. Where appropriate the brief answers include a discussion of the treatment factors underlying the particular point of view expressed.

What children should be considered as potential patients in an inpatient mental health facility?

All children whose difficulties are of a psychological and behavioral nature and who must be treated outside the community should be considered as a group. Distinctions between them must indeed be made, but they cannot be made on diagnostic grounds. These distinctions can only be made on the basis of differential treatment needs.

Where should it be located geographically?

All institutions for children should be in the community they serve. Centralization of such services is a false economy. Sparsely populated areas might provide the one exception to this rule, although even here I would urge serious attention to the possibility of setting up decentralized, smaller units.

What is the optimum size for such an institution?

With regard to size, 20- to 40-bed units seem to be optimum.

What should its auspices be, and how should it relate to other community services for children?

It is of the highest importance that such inpatient facilities be part of an integrated network of services to children. In most instances, it would seem to be desirable for this network of services to be operated under community, rather than State, auspices. There should be a close, systematic, and free-flowing relationship between special school programs, day hospitals, child guidance clinics, foster care programs, family agencies, and a range of inpatient mental health facilities for children.

In order to discuss the desirable characteristics of the inpatient facility itself, it is useful to outline some of its qualities in terms of a comparison between the large, centrally operated State hospital setting as opposed to the smaller, decentralized institution giving intensive treatment. The standard used is the relative capacity of the two types of institutions for meeting the treatment needs of the children for whom they care. This is not to say that other standards are not pertinent. Cost and administrative feasibility, among others, pertain, but the choices will be discussed here principally in terms of their clinical effectiveness.

To be therapeutically effective any institution dealing with children must have certain characteristics. While some of these characteristics are more important for one type of child than another, in the main they may be thought of as common to all good facilities.

The institution must be able to create an atmosphere which is hospitable to child life. To use Fritz Redl's phrase, it must be "psy-

chologically hygienic." While the concept of atmosphere is elusive at best and can be achieved or missed in countless ways, it represents a summary judgment on such matters as location, architecture, grounds, decoration and furnishings, available materials, and the attitudes of patients and personnel toward themselves and each other. Recognizing that this quality is dependent upon a multiplicity of factors, in a general way by atmosphere we mean our understanding that a particular institution is or is not a good place for any child to live in. This quality may generally be described by such adjectives as "warm," "supportive," "tolerant," "kindly," and "flexible."

The development of therapeutically meaningful adult-child relationships is of key significance in the treatment of most of these children. We would wish to see them develop with a number of different people: the child care worker, teacher, psychotherapist, caseworker, and group worker. Recognizing once again the wide variations as to philosophy and technique on this point, the sine qua non for such relationships is a high personnel-patient ratio in the institution, along with the opportunity to employ personnel suited by personality and training to this type of work. On both of these counts, State hospitals are at a disadvantage. While there is some flexibility as to personnel ratios, this tends to be limited by standards set elsewhere in the State hospital system.

So far as the caliber of the personnel is concerned, the problem here, among others, is fitting a new profession into on-going civil service practices. Touching only briefly on this complicated question, it may be pointed out that the profession of counselor or residential child care worker is in the process of development. For some time, we will look to many disciplines to provide us with workers in this field. It is difficult to do this within ordinary civil service procedures. In addition we are looking for people who are equipped with certain intangible personality assets which suit them to this work. We wish, as Dr. Paul Lemkau has put it, to be able to hire "that gleam in the eye." On both of these scores, maximum freedom in personnel practice is highly desirable.

Tolerance, flexibility, and individuation must characterize the institution. These three adjectives are chosen from what might be a considerably longer list to describe qualities of the institution which may be thought of as especially therapeutic, and qualities especially relevant to the size of the institution. It is the goal of a residential treatment setting to be something different from residence plus treatment. It should not be thought of as a hotel where one lives while receiving psychotherapy. The purpose, rather, is to use all aspects of the child's life in the institution for therapeutic purposes. To this end, it must have, among other things, a high tolerance for the symptomatic expressions of the child's illness and a great deal of flexibility so that it can manage his life according to clinical indications rather than some standard practice. As a simple illustration, we might take visiting. The needs of a large institution usually dictate a fairly regular visiting schedule for parents while home visits for the children are often difficult to arrange. Clinical considerations, however, may indicate flexibility in this area. Other examples would be bedtime routines and arrangements about food. In the most general terms, we can say that the institution must be small enough and communication between its component parts must be good enough so that clinical insights gained in one area can be transmitted to, and acted upon by, the other people who have contact with the child.

The institution must be able to carry on a therapeutically oriented program with the families of the children it serves. Perhaps no other point speaks more forcefully against the establishment of institutions for children which are removed any distance from the families of the patients. Regardless of one's therapeutic orientation, one cannot hope to treat children successfully and at the same time disregard the context in which they have become ill and to which they must return. Even those children who will not be able to return to their families will be profoundly influenced by them. It is necessary, therefore, that the institution be physically accessible and, in addition, have staff members who have the time and skill to maintain contact with the families in such a way as will be useful to them and their children. In addition to location this is a matter of staff

ratios and the caliber of personnel. By and large, it is quite difficult for large institutions serving a wide geographic area to maintain frequent contacts with the families of their patients, and it is frequently difficult for them to hire a staff for this purpose in the numbers required to do an effective job.

The child's separation from the community, and his return to it, must be managed in a therapeutically effective way. These are often crucial periods having great effect on the child's willingness to accept treatment and his ability to succeed after leaving the institution. These special instances deserve mention because they bear particularly on the question of location. It is especially valuable, for example, for a child to make preadmission visits to the institution in order to become acquainted with it, and it is also valuable for the return to the community to be a gentle transition. To the degree that he can, for example, return to a public school, join a Boy Scout troop, and so on, before actually leaving the residence, the final separation is more likely to be successful.

In a variety of ways, a close interrelationship with an inpatient mental health service can be of great value to a community. It can keep allied professions informed on the child care needs that it perceives in the community by virtue of its special position as an "end of the road" institution; it can serve as a site for research; it can be a training instrument for a range of professions.

An institution giving intensive treatment can be quite valuable, for example, to normal foster care institutions. We know that these congregate care institutions are serving a different population today than they did formerly. The wider availability of services holding families together, the decreased number of orphans, better economic opportunities, and the increased use of foster homes have all operated to reduce the number of "normals" in the "normal" foster care institution. The remaining children are almost all deviant. By sharing information with these institutions, the residential treatment home can augment their capacity for dealing with disturbances in the children they serve.

On the question of cost, one of the chief points in favor of larger, centralized institutions is that they can be run more economically. It is apparent, however, that this applies less directly to the sort of treatment institution for children with which we are concerned here. A large measure of the increased cost of such an institution comes directly from personnel costs. These are not amenable to reduction without actually reducing service. Consolidation and centralization will be effective in reducing costs only so far as they apply to administration. Moreover, the decentralized institution is in a position to use many already established facilities, such as schools and recreational resources, at little or no cost.

Role of the State

What, then, is the proper role of the State with regard to the development of this type of service? It may be outlined as follows:

Within the population served there are differences in age, sex, symptomatology, and treatment needs. A balanced program within an institution and a balance of institutions within the State need to be maintained. Leadership in this regard on the State level is important. There is a natural tendency to respond to the most pressing need in the community first. This means that other classes of children will not be cared for. By and large, the first group served are the 9- to 12-year-old aggressive boys. Next come the younger borderline and schizophrenic children. Girls, mostly, are not served. The older children in the 13- to 16-year-old range, with special problems of manageability, treatment, and security, are usually not dealt with. It is therefore the obligation of the State to exert influence to create a balance in the types of institutions.

On the State level, interdepartmental coordination must be approached by integration of related State departments—mental hygiene, social welfare, education, corrections, and health. This structure will, of course, be different from State to State, but there is a universal need for a multidiscipline approach on the State level, enabling local counterparts to develop and function.

State leadership and supervision are needed

in order to set and maintain standards for residential treatment centers. There is a tendency for everybody to climb on the residential treatment bandwagon. To some extent, this is financially determined. An institution with an inadequate program and a dwindling population may, in all good faith, feel that by hiring a part-time psychiatrist it has converted itself into a residential treatment home. In a more general way, the newness of the field and the lack of adequate clarity as to the necessary professional competence make it necessary that an on-going high-level process of setting standards and maintaining them be carried out.

The problem of staffing inpatient mental health services is a complex and difficult one. We are dealing here with a relatively new field without reliable traditional sources of personnel. A wide range of professional disciplines is involved, among others, residential child care workers, psychiatrists, psychiatric nurses, social workers, and special education teachers. In order to train people for work in this field, financial support during the training period and the development of stimulating training programs must be undertaken. While individual institutions have an interest in and responsibility for the maintenance of such programs, assistance from the State will be required for their full development.

The extent and nature of financial support certainly need to be debated to the degree that it provides one of the levers for starting services and for maintaining their quality. Policy in this area has extensive implications. It is clear, however, that in addition to the training grants described above, some money must be available on a State level for the addition of those services which will enrich and make therapeutic the residential program. It may very well be, too, that capital construction funds, which would have been ordinarily directed toward the development of large centralized institutions, should be made available for the conversion of certain congregate care centers for their new role as inpatient mental health facilities.

There is considerable debate as to whether a State should make capital construction funds available to local communities or agencies. In general, it has been a principle of administration in New York that the State should run any institutions which it constructs. At the same time, communities need assistance for this purpose.

As for professional leadership, there are 15 unanswered questions in this field for every one we think we know something about. Providing professional leadership and research, pooling and communicating experience—all these are continuing and on-going obligations of a State department.

PHS Employs Engineering Students

Fourteen college and university engineering students have been selected for summer employment by the Public Health Service under the commissioned officer student training extern program.

Engineering students are included for the first time in this program, designed to attract young people to careers in public health.

Students recommended by their deans apply for reserve commissions as trainees in the Public Health Service, where a review board passes on their qualifications and references. Those selected are assigned to Public Health Service programs at the Robert A. Taft Sanitary Engineering Center, Cincinnati, Ohio, the National Institutes of Health, Bethesda, Md., the Communicable Disease Center, Atlanta, Ga., the Division of Indian Health, Washington, D. C., and various regional offices.